



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HARRIS METHODIST – FORT WORTH
3255 W PIONEER PKWY
PANTEGO TX 76013-4620

Respondent Name

FEDERAL INSURANCE COMPANY

Carrier's Austin Representative Box

Box Number 17

MFDR Tracking Number

M4-07-6709-01

MFDR Date Received

June 11, 2007

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim has been partially reimbursed; however, it was not paid according to the Acute Care Hospital Fee Guidelines set forth by the TWCC. . . . This claim meets all of the criteria defined by the SOAH docket and should have been reimbursed \$83,073.86 . . . With no implant charges I do not understand how the carrier can claim this doesn't meet Stop-Loss."

Amount in Dispute: \$66,598.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Admission At Issue Is Not Eligible for Stop-loss Reimbursement: (1) It was a trauma admission; (2) It Did Not Involved Unusually Costly And Unusually Extensive Services."

Response Submitted by: Downs Stanford, PC, 115 Wild Basin Road, Suite 207, Austin, Texas 78746

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
October 12, 2006 to October 24, 2006	Inpatient Services	\$66,598.20	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401 sets out the fee guideline for acute care inpatient hospital services.
3. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:
- W10 – NO MAXIMUM ALLOWABLE DEFINED BY FEE GUIDELINE. REIMBURSEMENT MADE BASED ON INSURANCE CARRIER FAIR AND REASONABLE REIMBURSEMENT METHODOLOGY. REDUCED TO FAIR AND REASONABLE.
 - 97 – PAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE. THE REIMBURSEMENT FOR THIS LINE ITEM HAS BEEN INCLUDED IN THE PAYMENT RECOMMENDATIONS(S) FOR ALL COVERED SERVICES WHICH ARE REPORTED ON ANOTHER LINE OR LINES.
 - 16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. TO REVIEW THIS CHARGE A COPY OF THE INVOICE DETAILING THE COST TO THE PROVIDER IS NEEDED. WE ALSO NEED THE IMPLANT RECORD IF APPLICABLE.
 - W4 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION.

Findings

1. This dispute relates to inpatient hospital services with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5)(A), which requires that when “Trauma (ICD-9 codes 800.0-959.50)” diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 824.0. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
2. 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers’ compensation health care network shall be made in accordance with subsection §134.1(d) which states that “Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available.”
3. 28 Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable.” Review of the submitted documentation finds that:
 - The requestor’s position statement asserts that “This claim has been partially reimbursed; however, it was not paid according to the Acute Care Hospital Fee Guidelines set forth by the TWCC.”
 - The Division’s former *Acute Care Inpatient Hospital Fee Guideline* at 28 Texas Administrative Code §134.401 is not applicable to the services in dispute. Per §134.401(c)(5)(A), when ICD-9 codes 800.0-959.50 are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Therefore, the applicable rule for reimbursement is found under §134.1(d).
 - The requestor asks for reimbursement under the stop-loss provision found in former 28 Texas Administrative Code §134.401(c)(6). The requestor’s position statement asserts that “This claim meets all of the criteria defined by the SOAH docket and should have been reimbursed \$83,073.86 . . . With no implant charges I do not understand how the carrier can claim this doesn’t meet Stop-Loss.” The respondent contends that “The Admission At Issue Is Not Eligible for Stop-loss Reimbursement: (1) It was a trauma admission; (2) It Did Not Involved Unusually Costly And Unusually Extensive Services.” §134.401(c)(6) states that “The diagnosis codes specified in paragraph (5) of this subsection are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate.” As stated above, the Division has found that the primary diagnosis is a diagnosis code specified in §134.401(c)(5); therefore, the disputed services are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate pursuant to §134.1.
 - The Division has previously found that a reimbursement methodology based upon payment of a percentage of a hospital’s billed charges does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the adoption preamble to the Division’s former *Acute Care Inpatient Hospital Fee Guideline*, which states at 22 *Texas Register* 6276 that:

A discount from billed charges was another method of reimbursement which was considered. Again,

this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources.

Therefore, a reimbursement amount that is calculated based upon a percentage of a hospital's billed charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.

- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

_____ Signature	<u>Grayson Richardson</u> Medical Fee Dispute Resolution Officer	<u>December 14, 2012</u> Date
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_____ Signature	_____ Medical Fee Dispute Resolution Manager	_____ Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a *certificate of service demonstrating that the request has been sent to the other party.***

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.